ERA Enrollment Form PLAN YEAR 20 ____ ____

State of Wisconsin Employee Reimbursement Accounts Program

Complete this enrollment form if you wish to establish or continue a tax-free reimbursement account.

Administered for the State of Wisconsin, Department of Employee Trust Funds by:

WageWorks®

				Date of Birth
Social Security #		Employer (Please include the Name of the State Agency/U.W. Campus)		
Last Name (Please Print)		First Name		MI
Home Address	Street	City	State	ZIP
Work Phone ( )	Home Phone ( )	E-mail		

ENROLLMENT STATUS: ☐ **NEWLY HIRED** (Start Date:_____) Return form to your payroll/benefits office.
☐ **OPEN ENROLLMENT**: Fax enrollment form to 1-866-672-4780 or mail to: PO BOX 1840, Tallahassee, Fl 32302-1840

FLEXIBLE SPENDING ACCOUNTS

	MEDICAL EXPENSE ACCOUNT [Maximum allowable annual contribution is $2,500 per employee; Minimum allowable annual contribution is $100.]	**DEPENDENT DAY CARE ACCOUNT** **TAX FILING STATUS [PLEASE CHECK ONE]:** ☐ Married, filing separately **[maximum—$2,500]** ☐ Married, filing jointly **[maximum—$5,000]** ☐ Single, head of household **[maximum—$5,000]**
	Amount	**Amount**
Total Plan Year Dollar Amount	$_____	$_____
Number of Paycheck Contributions	_____	_____
Reduction Per Regular Paycheck	$_____	$_____

TERMS AND CONDITIONS

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal, state and Social Security taxes are calculated by the total amount of annual salary reduction indicated above.
- I understand that the contribution to my Social Security account will be reduced since contributions will be based on my income after reductions.
- I understand that any amount remaining in any Reimbursement Account that is not used during this plan year will be forfeited.
- I understand that the funds in one account cannot be used to reimburse expenses covered by another account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax returns.
- I understand that I am responsible for determining which expenses, if any, are eligible for reimbursement according to IRS regulations and the Wisconsin ERA Plan.
- I understand that the funds in the account can only be paid out to reimburse expenses for services actually incurred during my period of coverage.
- I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change In Status form with the Madison Office **within 30 days after** the Change In Status event.
- I understand and agree that my employer and WageWorks will not incur any liability resulting from either my participation in the account or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.
- **I understand and agree that, if I'm enrolling after the start of the ERA plan year (January 1), my effective date of coverage will be the first day of the month that begins on or after the date this enrollment form is received by my payroll/benefits office and only eligible expenses for services incurred on or after that date will qualify for reimbursement.**

Employee Signature **X**_____ Date Signed _____

For office use only:

Received Date _____ Payroll Center _____ Agency Code _____

Paycheck Frequency _____ Paycheck Effective Date _____ Coverage Effective Date _____ Payroll Authorization _____